DOH-BES
FORM 478 6/04

VERIFICATION OF NEED FOR ATTENDANT

_____ _____ _____/_____/_____
Client Name **Social Security #** **Date of Birth**

I, hereby authorize _____
(Medical Provider Name and Phone number)
to provide the information requested below to the Utah Department of Health, or the Department of Workforce Services. _____ /_____
(Client or Personal Representative) *(Date)*

Dear Provider:

The following information about the above named individual is being requested to determine if their physical or mental status requires that an attendant accompany them to medical appointments. Please answer the following questions and return the form to the caseworker indicated at the bottom of this form.

_____, is a patient under my care with physical or mental factors that would require an attendant to assist them when they use the UTA Bus system to go to medical appointments. YES: _____NO: _____

I expect this need to change. YES:_____NO:_____

If yes, approximately when and why will the need change?_____

_____.

_____/_____
Physician's Signature Date

Return Form to : _____(Caseworker Name)
Fax Number: _____
Mailing Address:_____

_____

If you have further questions please call: _____.